Colorado HIV/AIDS Strategy Meeting

September 8, 2014
Minutes

Location: Laboratory and Radiation Services LARS Training Room
8100 Lowry BLVD, Denver, Co 80230

Call-In Number for all of today's agenda – 877-820-7831 or 720-279-0026 210066#

Present: Cinzia (Left at 11:40am), Angy, Chris, Lisa L (Left at 12noon), Frank O, Lucio F., Darrel V.(left at 3:05), Jeff B, Peter R., Sven (Left at 11am), Kari H., Michael H., Mark T., Carol L., Brian S.(arrived at 10:30am and left at 11:40am), Scott G., (arrived at 10:30am) Carol W.A. (arrived at 10:40am)
Staff: Angela G., Jennifer D. (Left at 11:40am), Jennett B., Todd G., Anita, Rebecca J., Bob B., Mel M., Sue P., Rose Marie N., Steve D.C., Maria L., Kelly V.,
On the phone: Nancy S. (left at 11am), Ebony, Arthur P., Aaron (left at 11:40am), Lynette (CDPHE-left at 11:40am), James (left at 11:40am), Lilly C. (left at 11:40am)

Meeting Objectives:

- A Thorough Review of the Draft Plan
- A Plan that Reflects True Community Engagement

10:00 Introductions, Ground Rules for Meaningful Engagement

10:10 Reminder – Overview of Planning Process, Schedule and Milestones

- March – Beginning the Process, Epidemiology
- May – Care Sections of the Plan
- July – Prevention Sections of the Plan --- you are here
- September – Review and Refinement of the Full Draft Plan
- October – Final Version of the Plan – Community Concurrence

10:15 Plan Review and Revision – Section by Section

Document Overview pointing out specific items that came from previous meetings, reviewing where they are in the text:

- Creating a base of prevention messages for everyone and escalating services for those most in need of them with HIV+ at the top
- Stigma
- Anything of particular note in target populations
- The Integration of Prevention and Care – along the continuum

Sections that had some major changes made to it, reviewing how feedback make it into these revisions, we broke out into 5 groups:

Basic Package of Prevention Services: Transformative Model – Universal, Selective and Indicated and crossing all those boundaries is Mental Health and Substance Abuse. Promotion and Policy Intervention.
Page 12 – Continuum of Intervention Services
Pages 20-22 – Universal, Selected and Indicated Prevention. What are packages of services available for the broadest populations we serve.
How do you define risk groups?
Page 17-18 – tried to incorporate data from the National Surveillance report
Page 19 – Networks, systems status and Challenges
Page 20 – P2 and P3 discuss better integration
CDC Recommends you start with the way people are diagnosed,
Stigma and Reduction plan – Goal U4 p. 21
P5 – Increase funding opportunities for HIV services through legislative tax initiatives.
Women's section -

10:45 – Chapter 3 - Colorado HIV/AIDS Epidemiological Profiles and Surveillance Maps
HIV Disease in Colorado, Colorado State Characteristics, Epidemiological Trends in HIV Disease in Colorado, High Risk Populations

HIV Disease in Colorado

- By December 2012, 11,543 persons were known to be living with HIV or AIDS in Colorado.
- Acquisition of HIV disease in Colorado is still overwhelmingly driven by sexual exposure, primarily among men who have sex with men. accounted for 74.4 percent
- Among females, heterosexual transmission represented 58.3 percent of newly diagnosed adult HIV cases in 2012.
- Diagnosed cases of HIV/AIDS remain geographically centered in the Front Range and urban population centers of Colorado.

Colorado State Characteristics

- Colorado's population was 69.6 percent White, 21.0 percent Hispanic, 3.8 percent Black/African American, 2.9 percent Asian/Pacific Islander, 0.6 percent American Indian/Alaskan Native and 2.0 percent comprised of Two or More Races.

Discussion Section:

- Page 6, Colorado State Characteristics – The unemployment rate is confusing consider removing it.

Epidemiological Trends in HIV Disease in Colorado

- By the end of 2012, an estimated 11,543 Colorado residents were living with HIV disease
- Blacks continued to be disproportionally affected by HIV disease and represented 14.6 percent of PLWHA (prevalent cases of HIV and AIDS), while comprising only 3.8 percent of Colorado's population. The 25-29 year old age group accounted for the largest proportion of newly diagnosed HIV cases (19.1%) in 2012. Ninety-five percent of newly diagnosed HIV disease cases were reported in urban counties in 2012.

High Risk Populations

- In Colorado, three distinct high risk populations were identified using surveillance data: men who have sex with men (MSM), persons with injection drug risk (IDU) and high risk heterosexuals (HRH). An additional high risk group contained in all risk populations in Colorado is defined as Late-Stage Testers or Stage 3 diagnosed HIV cases.

Men who have sex with men

- The majority of Colorado's HIV/AIDS cases can be attributed to MSM risk behaviors (65.1 percent of all cumulative cases).
- The number of new MSM HIV/AIDS cases remained relatively stable since 2009 among Whites, remained relatively stable the past 5 years among Blacks, and has been increasing since 2010 among Hispanics.
- Blacks were over represented in the HIV epidemic among MSM
- Hispanics were also over represented
- Young men ages 20-29 years were over-represented, accounting for 36.8 percent of the HIV epidemic and 15.0 percent of the male population.

Discussion Section:

Data – we are not looking at Prevenlance for MSM p.7, it is not saying there is a percentage that is infected with HIV. We should quantify with Blacks page 8, we are not looking closely enough and assessing the resources going to it. 38.3%...are we prioritizing enough resources.

Persons with Injection Drug Use risk

- The number of HIV/AIDS cases attributed to IDU remained small and caution should be taken when interpreting these numbers.
- Through December 31, 2012, a cumulative total of 3,459 cases of HIV/AIDS were associated with IDU or MSM/IDU risk.
- 80.3 percent were reported in men and 19.7 percent were reported in women. IDU and MSM/IDU comprise 17.8 percent of the total HIV/AIDS cases reported in

Colorado. Over the past five years, IDU-related cases of HIV/AIDS were most commonly diagnosed in the 20-29 age group.

- Among the 52 males diagnosed with HIV in 2008-2012 whose only risk was IDU, Whites account for 29 (55.8%) cases, Hispanics for 15 (28.8%) cases, and Blacks for 4 (7.7%) cases.
- Among females, the number of IDU-related HIV or AIDS cumulative cases (680) was four times smaller than for males. From 2008 to 2012, 21 cases of HIV or AIDS in females were directly related to IDU. Of this number, Whites accounted for 12 (57.1%), Blacks accounted for 4 (19.0%) and Hispanics constitute 5 (23.8%) cases.
- IDU HIV cases diagnosed during the five year time period of 2008 through 2012 were largely concentrated in urban areas. Urban areas reported 94.8 percent of cases, rural areas 4.3 percent, and frontier areas 1.0 percent of cases. This pattern of HIV/AIDS case distribution among urban, rural and frontier regions has remained fairly stable since the early 1980s.

High Risk Heterosexuals

- Heterosexual HIV transmission has increased slightly from 10.8 percent in 2008 to 12.0 percent in 2012.
- Females represented 74.5 percent
- Blacks made up 38.3 percent, while Whites made up 31.9 percent, and Hispanics comprised 19.1 percent.
- Heterosexual transmission of HIV was most commonly diagnosed in those persons aged 25-29 years representing 17.1 percent of cases.
- It is difficult to make an assessment of the number of persons in Colorado who engage in heterosexual contact that put them at high risk for HIV. A diagnosis of a sexually transmitted infection (STI) would suggest that the person had engaged in unsafe sexual practices. Specific HIV prevention strategies should be directed toward these persons. In 2012, 21,631 cases of chlamydia and 2,822 cases of gonorrhea were reported to CDPHE.
- Blacks accounted for 43.0 percent of cases, Whites accounted for 25.6 percent and Hispanics accounted for 21.7 percent of cases. Blacks were over represented among heterosexually transmitted HIV cases.
- The largest proportion (17.1%) of newly diagnosed cases occurred in the 25-29 year old age group.

Discussion Section:

Page 8 – Define High Risk Heterosexual. Consider adding additional components to the definition; for example sex with MSM, with IDU, with Transgender. Think through that – not missing another notable component. Prioritize.

Email Input - High Risk Heterosexual. I understand what you are up against in defining who is considered a high risk heterosexual, but I am not sure why there is such an apparent struggle against just including African Americans and Latinos as high risk somewhere in the definition on the basis of their disproportionate numbers. It is what it is. I think the conversation about geographical locations (neighborhoods and zip code) can be considered in some way for the general population, but it is a limiting approach if you stop there when it comes to these two target populations. While there are greater concentrations of African Americans is some zip codes, we live all over the metropolitan area—the same with Latinos. The high risk remains for African Americans and Latinos regardless of their geographical location. Therefore, trying to narrow down to geographical location (zip codes/neighborhoods) for these target populations is too restrictive. It is limiting in much the same way that setting a time line to applying for services (I think it was Kerri that raise the question about being too restrictive by placing a time limits for applying for service). Same concept. We don't want to screen people by making things more restrictive –timelines, zip codes, etc. applied inappropriately.

Infants born to HIV-Infected Women

- Of 136 pregnant women with HIV in Colorado from 2008 to 2012, there were four cases of confirmed perinatal transmitted HIV infection, and all were reported in 2008. Of these cases, two were born outside of the United States.

Late Stage HIV Diagnoses

- A late stage HIV diagnosis is defined as an AIDS diagnosis within 365 days of an HIV diagnosis.
- In 2012 in Colorado, the racial/ethnic distribution of late stage diagnoses was 49.7 percent White, 29.3 percent Hispanic and 17.6 percent Black.
- The mean age of those HIV late stage diagnoses was 40.
- Among late stage diagnoses, 63.0 percent reported MSM risk, 14.5 percent reported no identified risk and 12.0 percent reported heterosexual risk.
- Twelve percent of late stage diagnoses occurred in foreign born persons.
- The overall number and percentage of late stage diagnosed cases has been relatively consistent for the last ten years. The percentage has ranged from 29 to 37 percent. In 2012, 113 of 392 new HIV diagnoses were late stage HIV diagnoses (29%).

Discussion Section:

Hep C discussion seems to be missing, how are we going to include it? There is a Hep C plan and co-infection is addressed in there. We can make more reference to that plan, look at the two plans side by side and make sure content is referenced. Address the infection rates and ensures we are addressing Co-Infection in the Plan.

Page 6 – Reference to AIDS please clarify.

Maps - Legends are small however they are just an example of what maps we could do for the plan if you all decide they are helpful.
Individual number of cases, from 2009-2013 to protect data release policies. Number of individuals diagnosed in 2013. CO-HIP has been on a 5 county region, Denver Arapahoe, Adams, Douglas and El Paso.
Use best legend to help explain the rest of the maps. Last organization listed SOCUE.
HIV cases are not inclusive of AIDS, we are looking for geographic morbidity so maybe we can add in AIDS. Moving forward we can assess HIV disease by Stages 1, 2, 3.
Overview include breakdown of total number of people diagnosed with HIV so that we can see the difference.
These are not rates (not by 100k).
We welcome feedback on GIS to help.
These are helpful and should be included, take feedback on maps and incorporate into the new version of the plan.

11:10 – Chapter 4 - Colorado Continuum of HIV/AIDS Prevention and Care

Group read this Chapter and then there was a discussion:

Section 4a – Background and Context

Context, The National HIV/AIDS Strategy, Colorado HIV/AIDS Goals, Colorado HIV Care Continuum and Intervention Categories, Colorado and the National HIV/AIDS Strategy Goals

- Review of the Care cascade – in the current document there is a 20 year denominator, it would be better to limit that to 10 years. So we can update that in the next draft.
- Table 2 p. 15 why are so many blank? Having specific numbers is helpful, we can populate with what we have because we will need to have a baseline.
- Why don't we have a goal for reducing Heterosexual risks? Lets add Colorado specific goals to this plan.
- Footnote that perinatal transmission – is at 0% transmission.

12:00 – Section 4b – UNIVERSAL, SELECTIVE, AND INDICATED PREVENTION

Group read this Chapter and then there was a discussion:

Target Populations, Sub-Target Populations, Evidence of Need, Prioritized Strategies & Interventions, Scalability, Responsible Agencies & Groups, Performance Standard & Indicators, Timelines

- Can we do this more effectively if we had a prevalence rate baseline and aligned with what is outlined in the plan? Think this approach would help us be more

targeted. From a community perspective, race does not go away coming from a community AA that is dispropotionality can be addressed. Great data to suggest that it is not just race, there are a lot of other factors that cause HIV infection. Let's find out what it is and address it.

- We can measure things from a social determinants' of health so why isn't this included in the plan. Moving forward can we do a better job of utilizing data that will help us understand the social determinants' of Health.
- **Email Input - Race in the Plan** - the African American and Latino populations were captured: In terms of prevention, the significance of not lumping these populations under women as was suggested is that the disproportionate nature of these two populations in acquiring HIV and the cultural particularities of each is not considered.
- Page 17, what is the actual number of Colorado respondents? 1,500 (500 for 3 years summarized together). Mark will have to find out, we should clarify if ever or for the last 12 months. Page 15 – is difficult. Bob will ask NHBS to review all this stuff.
- Clarify an Exchange partner – define.
- There are definitions – please provide the important ones.
- Page 17 – Target populations, High Risk Heterosexual should be prioritized as 3rd. Refer to page 25 of Epi data (so it shouldn't be number 7 on the list). The reason the list was not re-prioritized based on data is because the prevention committee prioritized it this way.
- Evidence of need is not completely matching up, what are we backing those determinations with if it is not backing up with the data.
- P. 18 – Something to be added on Needle exchange, add some data here to advocate on a federal level.
- P. 22 – S6 – HRR includes debi's, etc. – that is fine. With CRCS is solely provided by health department, as focusing in on high risk negative people. Issue prevention committee might want to focus in on.
- P. 23 – Something concrete to look at is the percent from statewide estimate of MSM (that is missing). For race: look at Statewide estimates, How many AA, what is rate of infection, how many living with HIV? For Latinos the same thing.
- Broader definition of high risk heterosexual – look to page 8.

12:30 – Section 4c – EARLY IDENTIFICATION OF HIV INFECTION

Group read this Chapter and then there was a discussion:

Target Populations, Sub-Target Populations, Evidence of Need, Prioritized Strategies & Interventions, Scalability, Responsible Agencies & Groups, Performance Standard & Indicators, Timelines

- P.27 – Is described fully in overview – doesn't exist.

- P27 – 3rd paragraph, 5th line, HIV negative lab results are not reported. Scratch this line, get testing from 3rd party payers.
- P.26 – Reworking target populations – fix this.
- P. 29 – How often should we test MSM? How to stratify the sub-populations?
- p. 29 – number for social network testing, using this network to promote testing for their peers. Social. Email language to M.L.
- P. 30 – Home Testing…including home based home testing comes up and we keep talking about that and we did work on that, can we pick up the pieces. Use the Home testing Report for wording, where is the workgroup and when can it be convened? Is it something that we want to move forward on?
- P. 30 – Copy and paste mistake (vi) should say for HIV testing.
- P. 31 – Timeline – contracting for testing?
- P. 31 – Reporting to Alliance, make sure it reflects the new alliance timeline. Operate on a calendar year.

1:10 – Section 4d – LINKAGE TO MEDICAL HOMES

Group read this Chapter and then there was a discussion:

Target Populations, Sub-Target Populations, Evidence of Need, Prioritized Strategies & Interventions, Scalability, Responsible Agencies & Groups, Performance Standard & Indicators, Timelines

- P. 32 People with HIV who were formerly in care.
- Sub-target populations, Douglas counties, bad rates of linking people to care.
- P. 34 – Scaliability, 2nd PP – 1st bullet below, what is the difference between two numbers. 2016-2017 are off by one number.
- P. 34 – At least 3 months apart.

1:50 – Section 4e – ADHERENCE TO/RETENTION IN CARE

Group read this Chapter and then there was a discussion:

Target Populations, Sub-Target Populations, Evidence of Need, Prioritized Strategies & Interventions, Scalability, Responsible Agencies & Groups, Performance Standard & Indicators, Timelines

- P. 36 – Number two is a sub-set of number 1, but it is okay to leave it as such
- Capacity Issue – where there is value to do the work, discuss how to increase capacity in terms of retention in care. Yes we will need to step up capacity, the percentage – gap is big enough. Make it a priority for the Coalition to think about. Think about sustainability, keep funding adherence and think about how we target clinics where there is a bigger problem? Some providers have larger

numbers and there is not the personnel there, and then private clinic's do not have the same infrastructure to support retention and adherence. So we need to start thinking about those partners. It does require greater thought.

- Look at chronic disease management and HIV in that lens.
- Data - Moving toward the Stages 1, 2 and 3. Is this something we are going to start doing? Yes we will and it will help us to see the impact of Care and Treatment. It is in our system and we can collect it, timeline for changing to that system. Not sure.
- P. 37 – language to address medical adherence.

2:20 - Section 4f – BEHAVIORAL HEALTH SERVICES

Group read this Chapter and then there was a discussion:

Target Populations, Sub-Target Populations, Evidence of Need, Prioritized Strategies & Interventions, Scalability, Responsible Agencies & Groups, Performance Standard & Indicators, Timelines

- **This section had the most changes.**
- P. 46, first bulleted section, and assuming new diagnosis – this is not consistent.
- Performance standards and indicators – People offered screening.
- P. 45 – The result of the screening will be they need additional screening, we estimate that 75% will need further services. Work on language, what you are trying to say there is a need for these services based on ESBIRT screening. Clean up ESBIRT wording so that it is more consistent.
- P. 40 – Populations that have been prioritized, how is this aligning with the prioritized populations. Definition from HRH to include all women.
- Considering adding verbiage to highlight the potential Impact of Legalized Marijuana – High risk behaviors and Marijuana use?
- P. 39-40 – are those two sub-target populations listed in order, can you make them match. No we can't and we had extensive debate before including them in this way.
- P. 44 – Hep C screening.
- 4f – does this section focus on selective prevention or indicated prevention. It goes across all of them. Thinking about level of risk and screening, the levels of prevention will impact identification of issues.
- Provider Network is mentioned more in these sections – include it here.
- **Email Input -** Behavioral Health Chapter. I would also agree that instead of just targeting women, High Risk Heterosexuals is a better approach.

3:00 - Section 4g – INTENSIVE SERVICES FOR PEOPLE WITH THE HIGHEST RISK BEHAVIORS

Group read this Chapter and then there was a discussion:

Target Populations, Sub-Target Populations, Evidence of Need, Prioritized Strategies & Interventions, Scalability, Responsible Agencies & Groups, Performance Standard & Indicators, Timelines

- Added Critical Events Pilot – more scalability and info we have at this time.
- Change the title so it is not confusing, HIV infected verses High risk not living with HIV. Change title to include pilot's ability to expand.
- How can the state sustain the amount of funding? It would be important to see a side by side analysis; disease burden, funded services and gaps.
- Sub-target populations for those living with HV…Clarification.
- P. 48 – People who experienced sexual assault – not clear, add it to partner violence.
- P.49 – Time frame the 90 days, this is restrictive, work out protocol. Do not put the date in the plan, and add wording - provision for case by case basis.
- P. 51 – Number 3 - what constitutes high priority STI's – in general under the goals #3. Co-infected with HIV and STI?
- High Risk Heterosexual – Estimate: There are 1,316 HIV positive HRH and 2,810 sexual partners of these HIV+ people.
- The HIV negative partners are often unaware of their risk.
- What are the best "markers" for these populations that could be used to geographically direct HIV Prevention?
- Local STD rates (GC?CT? Syphilis?)
- Income Levels
- Educational Levels
- Cumulative prevalence rates, over past 5, 10, 20 years
- Race/Ethnicity
- Others?
- These are MARKERS for planning purposes; they do not automatically put a person at risk. We need to be careful with regard to these markers.
- What becomes important is having our rates documented. These are indicators of areas or sub-populations.
- For selective interventions, were gonna have to decide on some markers.
- Sue L. had looked at a lot of qualitative issues – we are sitting on top of more information we are looking at. Colorado is unique, large populations in small areas, people who have information, bi-sexual men (focus group to get some information). Look at the data in a different way, patterns, could identify social venues better, places where people are likely to connect.
- So do we need to develop a data strategy to address this?
- We need to get to a formula – that can help explain to the funder where we are in prevention and then care and treatment.

- How can we make sure that when we invest in prevention, we are making an impact?
- Figure out how we tie other resources together, gap analysis?
- Estimated numbers for people who are unaware of their status, how do you apply the 20%? Seattle estimates for HRH – 5% what is that analysis.
- STD follow-ups they get 2-4 newly identified people, the challenge is to drill down into the data and identify HRH risk.
- Report 2007, HRH – Susan, George and Kelly authors. Angela will send it out.
- Why are we brainstorming this data so late? Where is the NA for this plan? Work with Surveillance to see if we can map and put something together for the 12th.
- Sexual partners of MSM.

3:50 – Chapter 1 - Executive Summary
Chapter 2 – Acknowledgements
Chapter 5 – Collaborations
Chapter 6 - Planning Process
Appendices

3:50 – Ask for written feedback – to be sent to Maria.Lopez@state.co.us by COB Firday, September 12th.

3:55 Next Steps and Adjourn

Next Planning Meeting – to Complete the Colorado HIV/AIDS Strategy October 6, 2014 10:00 a.m. to 4:00 p.m.

Next Combined Meeting – Care Advisory Committee, Prevention Advisory Committee and Governor's HIV Care and Prevention Coalition – November 11, 2014, 10:00 a.m. to 4:00 p.m.